Polypoidal and giant molluscum contagiosum

The letter by Kumar and Dawn¹ on a case of solitary, giant penile molluscum contagiosum (MCV) merits further comment and clarification. We have observed a cardiac transplant recipient who was therapeutically immunosuppressed, with recalcitrant facial MCV, some of which are "giant MCV". This clinical entity does exist in non-HIV patients contrary to Kumar and Dawn's statement. We have just completed a clinical survey that showed a positive correlation between CDC categories B and C HIV disease and facial MCV, compared with genital lesions in stage CDC A and non-HIV clinic attenders (p < 0.001 Fisher's exact test) (table). The clinical and molecular study by Thompson *et al*² also demonstrates the facial predilection of MCV in advanced HIV disease, but not to the exclusion of genital

lesions as in Petersen's study.³ This suggests that genital MCV occurs in HIV infected patients, as a sexually acquired infection early and once established may present in an opportunist form; however, the clinical site manifesting is determined by the degree of immunosuppression.

A J REA
B T GOH
Department of Genitourinary Medicine,
Ambrose King Centre,
Royal London Hospital,
London E1 1BB, UK

1 Kumar B, Dawn G. Polypoidal and giant molluscum contagiosum in an AIDS patient. *Genitourin Med* 1995;71:57.
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Anatomical sites of MCV infection in patients at HIV and GUM clinics

HIV status	Total no. patients with MCV	Site presentation	
		Face	Genital/trunk/limb
HIV CDC C	12	12 (100%)	0 (0%)
HIV CDC B	4	3 (75%)	1 (25%)
HIV CDC A	3	0 (0%)	3 (100%)
Presumptive HIV neg GUM patients	70	1 (1.43%)*	69 (98.57%)

*Cardiac transplant recipient.

Ignored trichomonal infestation diagnosed by Papanicolaou smear

The retrospective study of Petersen *et al*¹ on ignored trichomonal infestation diagnosed by Papanicolaou smear reiterates the value of routine saline wet-mount phase contrast microscopy as part of the diagnostic screening in the evaluation of women (and men with urethral discharge) who attend an STD clinic.²

A recent audit in our unit evaluating the efficacy of saline wet-mount phase contrast microscopy in the diagnosis of trichomoniasis in the period 1992-1994 confirms its continued usefulness as part of the diagnostic tool in screening attenders at a genitourinary medicine (GUM) clinic. Our unit in the north east England region serves a catchment population of about 320,000 residing in the coastal city of Sunderland and its suburbs. As a routine, after obtaining relevant medical, sexual, contraceptive histories and a genital examination, a saline wet-mount smear from the posterior vaginal fornix in women and a urethral scrape from men with urethral discharge were examined by phase contrast microscopy. They were initially scanned at × 100 looking for motile trichomonads and then at × 400 to confirm motility and morphology of trichomonads. Samples from the posterior vaginal fornix and urethral discharge were inoculated into commercially available *Oxoid Trichomonas Medium* (Basingstoke, UK Ltd), incubated at 37°C and examined after two days and seven days for motile trichomads. Gram-stained smears were done on vaginal, urethral and cervical sites including cultures for *Neisseria gonorrhoeae*, *Gardnerella vaginalis*, *Candida albicans* and *Chlamydia trachomatis* (ELISA). Serological tests were done for syphilis and hepatitis B surface antigen routinely and for HIV (I and II) antibodies on request after appropriate counselling. Cervical cytology was done

according to the National Health Service Cervical Screening Programme guidelines. We modified the guidelines by screening opportunistically sexually active teenagers—those aged under 20 years, in particular sexual contact(s) of men infected with genital warts.

In the period 1992-1994, 45 cases of trichomoniasis were identified (43 women and two men). Of the men; one was a single 24 year old who attended as an asymptomatic contact. Phase contrast microscopy of saline wet-mount urethral scrape showed motile trichomonads confirmed by culture. The other was a married 34 year old who attended with a urethral discharge. Clinical examination and microscopic review of Gram-stained urethral smear and two glass urine test provided an initial diagnosis of non-gonococcal urethritis. He was commenced on a dose of 500 mg oxytetracycline twice a day for two weeks while awaiting his cultural diagnosis. Phase contrast microscopy was not done. Trichomoniasis was confirmed from culture. His contact seen elsewhere had confirmed trichomoniasis.

The mean age of the 43 women was 22.5 years, range 14-43. Of these women 44.2% (19) were aged under 20 years; 95.3% (41) declared themselves single, separated or divorced. Contraceptive use reported were; oral contraceptive pill 30.2% (13), depo-provera 4.6% (2), intra-uterine coil device 2.3% (1). No form of contraceptive use was reported by 53.4% (23) and 9.3% (4) were pregnant.

The source of referral was: 41.8% (18) were self referred, 30.2% (13) were referred by their GP, 16.7% (7) attended following a provider referral and 11.6% (5) were referred from the Antenatal Clinic or Gynaecology Department.

The reported reason for attendance was; vaginal discharge in 53.4% (23), genital wart infection 16.2% (7) and 9.3% (4) attended requesting only testing for HIV antibodies

but agreed to infective screening after counselling. The rest attended for a check-up.

Other STDs identified in the women (sometimes in combination) were *Neisseria gonorrhoeae* in 4.6% (2), *Chlamydia trachomatis* 18.6% (8), *Candida albicans* 18.6% (8), genital warts 16.2% (7), *Gardnerella vaginalis* 6.9% (3), *Herpes simplex* Type 1 in 2.3% (1). An incidental finding of septate vagina was noted in a 15 year old seen because of genital warts.

In this study, saline wet-mount phase contrast microscopy identified 88.3% (38) of the women and 50% (1) of the men at the first attendance, allowing prompt treatment. Subsequent culture identified 95.3% (41) of the women and 50% (1) of the men. Opportunistic cervical cytology was done in 14 of the women and trichomoniasis was identified only in 75.3% (11) confirmed by culture.

Various hypotheses for the decline in incidence of trichomoniasis had been made,³ but we believe that routine phase contrast microscopic examination of saline wet-mount vaginal material from the posterior fornix and urethral discharge should remain as an essential screening modality for trichomoniasis in STD clinics, recognising the failure rate of various culture medium.⁴ However, direct immunofluorescence with monoclonal antibodies holds promise as a sensitive and specific alternative of cultures for the rapid detection of *Trichomonas vaginalis* in clinical specimens.⁵

T C HARRY
S RASHID
K M SARAVANAMUTTU
Department of Genito-Urinary Medicine
T L SHRESTHA
Department of Medical Microbiology,
Sunderland District General Hospital,
Kayll Road, Sunderland
SR4 7TP, UK

Address correspondence to: Dr Tubonye C Harry.

1 Petersen CS, Carl L, Alnor D, Thomsen U, Thomsen HK. Ignored trichomonal infestation diagnosed by Papanicolaou smear. *Genitourin Med* 1995;71:257-8.
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The value of colposcopy in genitourinary medicine

In view of Griffiths' further comments on colposcopy in genitourinary medicine,¹ it seems that a brief final observation may be justified.

The original paper² was a retrospective report which looked back historically to 1986. The paper clearly identified that the colposcopy approach that was being explored was exactly that of the very wide use of the colposcope as practised throughout Germany, Spain, Italy and much of France and South America. Quite simply magnification of the cervix is considered to be a better way to detect a range of cervical diseases. This includes infectious and inflammatory conditions. Clearly this broad approach can

link into the narrower concept of colposcopy practised specifically in response to cervical dyskaryosis detected by the Cervical Cytology Screening Programme.

The application of colposcopy within genitourinary medicine should be complementary to, and certainly not in competition with colposcopy as practised widely and effectively in gynaecology throughout the UK.

It was helpful that we may both conclude with complete agreement "carefully prepared prospective research" is required, and for this reason it was not appropriate to consider primary colposcopy within the context of the NCN Report.³

T R MOSS
Doncaster Royal Infirmary,
Armthorpe Rd, Doncaster DN2 5LT, UK

- 1 Griffiths M. The value of colposcopy in genitourinary medicine. *Genitourin Med* 1995;71:4270.
- 2 Moss TR, Hawkswell J, Fogarty B, Dadswell C. The value of primary colposcopy in genitourinary medicine—a six year review. *Genitourin Med* 1994;70:191–5.
- 3 The role of genitourinary medicine cytology and colposcopy in cervical screening: Does the GU female population merit a different cytology/colposcopy strategy? NHS Cervical Screening Programme. National Coordinating Network, Oxford 1994. Moss TR, Hicks DA, eds.

BOOK REVIEWS

Genital Warts. Human Papillomavirus Infection. Edited by ADRIAN MINDEL. London. Edward Arnold. (Pp 292; £48.) ISBN 0-340-57924-2

This multi-author monograph will be of immense interest not only to clinicians dealing with HPV infection and its sequelae, but also to molecular biologists working in the field of HPV research who wish to get an insight into the clinical aspects of this infection. It's written in a succinct but eminently readable style and covers the common clinical manifestations, in addition to the virology, epidemiology, laboratory diagnosis, immunology, and prospects for vaccines.

The first chapter, *Virology*, assumes little and gives a very good overview of the subject. After reading this chapter the "papillomata talk" which inevitably confounds the newcomer to this field starts to make sense. Tables, line diagrams, and electron micrographs are all of the highest quality and used to good effect. The table listing HPV types characterised to date shows the rate of progress in this area; 60 are described in the text; approximately 80 types are now characterised.

Cathy Critchlow and Laura Koutsky's chapter on epidemiology is a masterly overview of a complex subject. The section on issues in interpreting prevalence studies was particularly well presented and highlights many of the reasons for the marked variations in reported prevalence rates.

The seven chapters on the clinical aspects

of papillomavirus infection cover the much written about association of papillomavirus with cervical cancer and precancer in addition to the association with other anogenital tract tumours including penile and anal cancer, treatments modalities and a particularly useful overview on HPV infection in children.

Immunology of HPV infection is covered in a single chapter written by Margaret Stanley *et al.* The clarity of this particular chapter on a rapidly evolving subject is excellent and gives one a good introduction to this complex area. It is as up to date as it is possible to get and it was particularly pleasing to see as yet unpublished work described.

My only criticism of the book was the order in which the chapters appeared. The last two chapters would have been more appropriately sited before the chapters on the clinical aspects rather than following them. I believe that it will be a long time before any other book on this subject will be published which will be as comprehensive but at the same time be as reader friendly. I would recommend this as an essential book in any genitourinary medicine clinic library, and it will serve as an invaluable reference source for those involved in HPV research.

DAVID ROWEN

SEXplained . . . The Uncensored Guide to Sexual Health. By HELEN KNOX. London. Knox Publishing. 1995. (Pp 81; £9.99.) ISBN 0-952-6224-0-8

Genitourinary medicine or sexual health specialists may be interested in this book for a number of reasons. Some clinics may provide health educational books in waiting rooms as an alternative to jaded Sunday supplements. Written information is useful in supporting advice given by clinicians and of course any number of people with sexual health problems never use specialist services. Good self-help guides ought to direct patients to appropriate services.

The "uncensored" label is redolent of those gravel-voiced film previews at the cinema. And it is the author's stated intention to provide a hard-hitting, no-nonsense consumer guide. Whether or not this is the best approach is down in part to personal preference, but also to one's belief in the value of shock tactics as an approach to health promotion: do smokers change their behaviour after seeing diseased lungs in formalin? What is the effect of including full-colour photographs of diseased genitals in this book? Helen Knox quite clearly believes in giving the full picture. This presumably explains the cost which is much higher than for comparable publications but within the reach of institutions. Having opted for 12 colour plates, 5 are devoted to syphilis and another to herpetic breasts. Other com-

moner but perhaps less dramatic conditions are therefore neglected.

The book is easy to read with diagrams, cartoons, black and white photographs and a punchy question and answer style which ought to be accessible to the general public and a younger audience in particular. Some may want to give a more positive angle. It is worth stating for example that people can enjoy sex after an attack of herpes, that cervical cancer is slow to develop and therefore preventable, and that in Britain most people infected by hepatitis B do not develop cirrhosis and life-threatening liver disease.

Some clinicians would want to question the assertions that hepatitis C is more infectious than HIV or that NSU can cause difficulties in maintaining an erection. It is curious to find that lice and scabies cover more pages than HIV. There are additional disadvantages to being tested for HIV antibody, not given in the text, particularly social and psychological factors. I found the hepatitis chapter confusing as it did not always specify HBV, HCV, etc. The safe sex advice which aims to prevent all transmission of genital infections will be too prohibitive for some.

No book will suit all readers. 'SEXplained' will be just right for some and is sufficiently different to merit its place on the bookshelf. It is crammed with information, from condom-weakening lubricants to emergency contraception, and most common genital and sexually transmitted infections are discussed. It advocates safer sex, using GUM clinics and partner notification for STDs. In fact, even better than tucking it away on a bookshelf, consider leaving it out in waiting rooms and ask the patients what they think of it. Anything which opens up discussion between client and clinician is helpful.

MARTIN JONES

NOTICES

British Society for the Study of Vulval Disease

The next meeting will be at the Robbins Centre, University of Plymouth, 11–14 July 1996. Enquiries should be addressed to Dr GD Morrison, Dept of Genitourinary Medicine, Freedom Fields Hospital, Plymouth PL7 4JJ, UK.

13th World Congress of Sexology: Sexuality and Human Rights

Venue: Palacio de la Música y Congresos. Valencia, Spain. 25–29 June 1997. Information and Registration: Technical Secretary: Europa-Travel, S.A. Hernán Cortés, 28 46004 Valencia-Spain. Tel: 34-6-352 45 47. Fax: 34-6-352 54 97.